DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse and
Mental Health Administration
Rockville MD 20857

3600

October 18, 1990

Dear Colleague:

In response to your inquiry, enclosed is a copy of the Report to Congress: Deinstitutionalization Policy and Homelessness. This report was prepared by the National Institute of Mental Health (NIMH) and submitted to the Congress by the Secretary of the Department of Health and Human Services on May 23, 1990. This report provides an historical overview of deinstitutionalization of mentally ill individuals, examines the growth of the homeless population, and analyzes the relationship between deinstitutionalization and homelessness. In addition, it reviews relevant Federal initiatives and, among a number of Action Steps, recommends the formation of a Task Force on Severe Mental Illness and Homelessness. This 18-month Task Force has a broad mandate to examine the systemic problems that make severely mentally ill people particularly vulnerable to homelessness.

The Task Force will review research findings and solicit expert advice to determine:

- Effective approaches for providing treatments and coordination of appropriate services to severely mentally ill persons, particularly those who are homeless;
- The prevalence, causes, and treatment of major mental illnesses among the homeless population;
- The causes and prevention of homelessness among severely mentally ill persons;
- Factors that impede access of severely mentally ill persons, particularly those among them who are homeless or at high risk of homelessness, to housing, mental health, income support, and human service programs.

Based on this review, the Task Force will prepare recommendations to be forwarded to the Federal Interagency Council on the Homeless outlining an appropriate course of action (including legislative proposals, regulations, and/or Executive Branch programs) so that the Executive Branch can assist States and localities in better meeting the housing, treatment and support needs of severely mentally ill and homeless mentally ill persons.

If you have any suggestions or comments you wish to convey to the Task Force on this report or on the broader topic of homelessness and mental illness, please send them to me at the address below.

Sincerely,

Irene S. Levine

Irene S. Levine, Ph.D., Director
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Enclosure

3600

DEINSTITUTIONALIZATION

POLICY AND

[redacted]

A Report to the U.S. Congress

In fulfillment of Section 603

Public Law 100-77

The Stewart B. McKinney Homeless Assistance Act

National Institute of Mental Health

Alcohol, Drug Abuse, and Mental Health Administration

U.S. Department of Health and Human Services

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EXECUTIVE SUMMARY

DEINSTITUTIONALIZATION POLICY AND HOMELESSNESS

A REPORT TO THE U.S. CONGRESS

Section 603 of Public Law 100-77, the Stewart B. McKinney Homeless Assistance Act, required the Department of Health and Human Services to conduct a study of the contribution of State mental health deinstitutionalization policies to homelessness. This report presents the findings, conclusions, and recommendations of that study.

Deinstitutionalization

"Deinstitutionalization" refers to an overall reduction in the use of State mental hospitals and a general increase in the use of community mental health services that has occurred over the past 30 years. Deinstitutionalization has been characterized by four trends:

1. **Reduction in numbers of State mental hospital residents:** In 1950, 512,501 persons resided in U.S. mental hospitals; by 1986 the number had fallen to 108,800, an 80 percent decrease.
2. **Diversion of patients away from State mental hospitals:** There has been a reduction in use of State mental hospitals in comparison with general hospitals, and a reduction in use of inpatient care in comparison with outpatient care.
3. **Decrease in average length of stay in inpatient mental health facilities:** The average number of days per inpatient treatment episode fell from 99 days in 1969 to 37 days in 1986.
4. **Expansion of community mental health services:** Episodes of outpatient mental health care increased from 379,000 in 1955 to 5.6 million in 1986.

Many factors coalesced to bring about deinstitutionalization. These include: exposes on poor conditions in State hospitals, advances in mental health treatment, changes in treatment philosophy, greater recognition of the legal rights of mentally ill persons, and incentives to States to shift some costs of mental health treatment to the Federal Government.

The change from an institution-based to a community-based mental health system has been positive in many respects. Assisted by psychotropic medications, other treatments and services, and/or support from family or friends, many severely mentally ill persons are able to live successfully outside of mental hospitals. Unfortunately, deinstitutionalization has been plagued by problems as well. Although there are many demonstrably effective community-based models of mental health care, such services are not widely available in all communities. Most communities lack an adequate range of supported housing options and suffer from a lack of coordination among social service agencies. The comprehensive community mental health system for the severely mentally ill population that was to

accompany the massive reduction of State mental hospital rolls has never fully materialized.

Homelessness

Section 103 of the McKinney Act defines a homeless person as one who "lacks a fixed, regular, and adequate nighttime residence" or whose primary nighttime residence is a shelter, a "temporary institution for individuals intended to be institutionalized, or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings."

No precise estimates of the size of the homeless population are available. A reliable estimate is that approximately 567,000 to 600,000 persons are homeless on any given night. Furthermore, homeless persons are socially diverse and have multiple problems and service needs, including physical and mental health problems, substance abuse problems, lack of income, and poor social supports. Approximately one-third of the homeless population suffer from severe mental illnesses such as schizophrenia, depression, manic-depression, and personality disorders. Approximately one-fourth of homeless people have had psychiatric hospitalizations in the past. These segments of the homeless population do not overlap completely; many homeless mentally ill people have never received psychiatric hospitalization, and many formerly institutionalized homeless individuals are not currently in need of mental health services.

Many factors contribute to homelessness, including homelessness among those with mental illness:

1. **Lack of affordable housing:** Between 1970 and 1980 approximately 1 million single room occupancy (SRO) units, almost one-half the Nation's total, were converted to other uses or destroyed. Moreover, the continuing deterioration of public housing units has also contributed to the shortage of affordable housing.
2. **Poverty:** A decline in the percentage of Americans living below the poverty level in recent years has been so minimal that it constitutes almost no change. The estimate of 31.1 million persons living below the poverty level in 1988 follows a plateau in this rate beginning in 1986. During the late 1970s and 1980s, the real value of many entitlement benefits also declined.
3. **Fragmentation of services:** Homeless people must negotiate complex bureaucracies to obtain housing, health care, employment, income support, and social services.
4. **Lack of personal and social supports:** Compared with other people, those who are homeless are more likely to lack personal and social supports or to have exhausted those they had.

Severe mental illness can also contribute to homelessness. Like physical disability, alcoholism, an abusive relationship, or old age, mental

disability can place one at higher risk of losing one's housing or employment, and can impede one's ability to cope with crises.

Relationship Between Deinstitutionalization and Homelessness

The relationship between deinstitutionalization and homelessness is extremely complex and difficult to analyze. Longitudinal follow-up data on mentally ill persons who were discharged or diverted from mental hospitals are not widely available. Statistics about the number of patients who were deinstitutionalized explain little about which patients these were, where they went, and how they fared.

Nonetheless, it is possible to make some general observations of the extent to which the deinstitutionalization policies of the States may have contributed to homelessness:

1. Deinstitutionalization was not a primary cause of homelessness in general. Two-thirds of the homeless population are not severely mentally ill, and deinstitutionalization bears no relationship to their homelessness.
2. Most deinstitutionalized, severely mentally ill persons are not homeless. Although no definitive counts are available for either the total deinstitutionalized population or the homeless mentally ill population, the former far outnumbers the latter.
3. Deinstitutionalization has contributed to homelessness among some severely mentally ill persons. The absence of comprehensive mental health services and residential supports, augmented by the overall shortage of affordable housing, the growth of poverty, fragmentation of services, and lack of supports, has left many mentally ill persons homeless. This is not to say, however, that all of these people are homeless solely because of their discharge or diversion from a mental hospital.
4. "Reinstitutionalization" will not solve the problem of homelessness in general or among mentally ill persons. In fact, reinstitutionalization is inappropriate for most homeless mentally ill persons. The real precipitating causes of homelessness seem to be the housing shortage, poverty, fragmentation of services, and breakdown in supports. Any solution to the problem of homelessness must address these causes. Rehospitalization is not medically necessary for most people who are severely mentally ill and homeless. The medications and therapies that spurred deinstitutionalization in the first place make it possible for most severely mentally ill persons to live in the community if provided with adequate supports.

Conclusion:

Our review of research on deinstitutionalization and its relationship to homelessness suggests that deinstitutionalization is only one of many

factors contributing to homelessness among mentally ill persons. However, for the many reasons described in this report, the mentally ill are overrepresented among the homeless.

Severely mentally ill individuals who are homeless require a range of housing and community support services in addition to mental health treatment. In our present system of care, responsibility for meeting these multiple needs is generally fragmented across different layers of Government and among different health, mental health, housing, and other human service agencies. While there are a wide range of Federal programs (outlined in Chapter VI of this report) available to provide assistance to homeless mentally ill persons, our findings suggest that Federal programs often inadvertently create barriers and financial disincentives to appropriate care.

Action Steps:

Further steps that the Department of Health and Human Services intends to take as a result of this review, in order to provide leadership to assist States and communities to respond better to the needs of the homeless mentally ill, are:

- The Department of Health and Human Services will be announcing a new round of FY 1990 Mental Health Demonstration projects using McKinney Act and other PHS resources to improve treatment and care of severely mentally ill individuals who are homeless or at risk of becoming homeless; and

- The Department of Health and Human Services will be collaborating with HUD on programs and projects which combine Mental Health treatment with housing assistance.

In addition, the Department of Health and Human Services has accepted a recommendation from the Director of NIMH that a Task Force on Severe Mental Illness and Homelessness be formed to prepare a plan for Federal research to systematically examine:

-The causes and prevention of homelessness among severely mentally ill persons;
-The prevalence and types of major mental illnesses among the homeless population;
-The causes and treatment of severe mental illness;
-Effective approaches for providing treatments and coordinating services to severely mentally ill persons, including those who are homeless; and
-Factors that impede access of severly mentally ill persons, particularly those among them who are homeless or at high risk of homelessness, to housing, mental health, income support, and human services programs.

Because of the importance of this issue, the Department of Health and Human Services will designate the Director of the National Institute of Mental Health to chair this Task Force on Severe Mental Illness and Homelessness, with assistance from the heads of the Health Care Financing Administration, and the Social Security Administration. Other participants will include representatives of HUD, DOL, and VA; State and local levels of government; non-profit providers and research organizations; and members of the private sector, who either finance, manage, or provide services to the homeless mentally ill.

Once accepted, the plan developed by the Task Force on Severe Mental Illness and Homelessness shall be forwarded to the Federal Interagency Council on the Homeless so that the Executive Branch can outline a course of action (including legislative proposals, regulations, and/or Executive branch programs) that will enable States and localities to better meet the housing, treatment, and support needs of severely mentally ill and homeless mentally ill persons.

The Stewart B. McKinney Homeless Assistance Act established the Federal Interagency Council on the Homeless to coordinate all federal programs for homeless persons, and provide technical assistance to states, local governments, and other public and private nonprofit organizations which are serving homeless persons. The Task Force on Severe Mental Illness and Homelessness will have a distinctively different mandate. It will focus not on homelessness broadly, but upon homelessness among severely mentally ill persons. By addressing the systemic problems that make severely mentally ill people particularly vulnerable to homelessness, this could help abate the growth of this sizeable segment of the homeless population.

I. INTRODUCTION

In July 1987, Congress approved and the President signed Public Law 100-77, the Stewart B. McKinney Homeless Assistance Act, which authorized a comprehensive array of housing, shelter, food, health and mental health care, substance abuse treatment, job training, education, and veterans' services for homeless persons. Section 603 of the Act required that the Secretary of the Department of Health and Human Services conduct a study to determine "the extent to which the mental health deinstitutionalization policies of the States are contributing to the problem of homelessness." It also required that the Secretary submit the findings of such a study to Congress, "including any recommendations... with respect to administrative and legislative initiatives that can reduce the number of chronically mentally ill individuals who are homeless." The Secretary delegated responsibility for this study to the National Institute of Mental Health (NIMH).

This report presents the results of that NIMH study and the recommendations stemming from it. It is based upon a review of the literature on deinstitutionalization and homelessness and a review of the experiences of five States (conducted by Policy Resources, Inc., in Washington, D.C., Contract No. 278-87-026 (PA)), augmented by NIMH data.

Section II of the report provides an historical overview of the deinstitutionalization of the mentally ill population, and Section III examines the growth of the homeless population. Section IV analyzes the relationship between homelessness and deinstitutionalization, and Section V presents conclusions regarding that relationship. Section VI reviews Federal initiatives on behalf of mentally ill and homeless persons. Further steps to be taken by the Department of Health and Human Services are presented in Section VII.

II. DEINSTITUTIONALIZATION

Deinstitutionalization* and homelessness* are both complicated topics in their own right. Before analyzing the relationship between them, it is necessary to understand their individual contours. This section of the report provides a brief background on severe mental illness and deinstitutionalization. It addresses the following questions: How many persons in this country are severely mentally ill? What services do severely mentally ill people need? What factors contributed to deinstitutionalization and what was its course? What were some of the successes and problems related to deinstitutionalization?

Number of Severely Mentally Ill Persons in the United States

Estimating the number of severely mentally ill* individuals in this country is a difficult task because the population is dispersed across many settings. Based upon a survey of a range of mental health programs in each State, the National Institute of Mental Health (NIMH) estimates that in 1977 there were 2.4 million severely mentally ill persons in the United States. Of these, approximately 900,000 resided in nursing homes or mental hospitals, and about 1.5 million lived in the community, some with occasional brief hospitalizations. By 1985, the severely mentally ill population had increased moderately to almost 2.8 million, with about 1.2 million residing in nursing homes or mental hospitals and 1.6 million in the community. The proportion of the general adult population with severe mental illness has remained relatively constant at about 1 percent over the years (U.S. Department of Health and Human Services, 1980; Goldman, Gattozzi, and Taube, 1981).

Service Needs of Severely Mentally Ill Persons

Severely mentally ill persons often have multiple, long-term disabilities that interfere with activities of daily living. These may include difficulties in securing or maintaining employment or housing, sustaining relationships, or meeting basic subsistence, health, and mental health care needs. To assist severely mentally ill people with these disabilities, the following types of services should be available in every community (National Institute of Mental Health, 1987b):

- client identification and outreach
- mental health treatment
- crisis-response services
- health and dental care
- housing
- income support and entitlements
- peer support

* See definitions, Appendix A.

- o family and community support
- o rehabilitation services
- o protection and advocacy
- o individualized case management

Prior to deinstitutionalization, State hospitals provided for most of the needs of severely mentally ill persons. Now mentally ill individuals in the community must seek out these services on their own, often from diverse agencies.

Factors Contributing to Deinstitutionalization

During the past 30 years, the U.S. mental health service system has undergone a dramatic transformation. The care of the severely mentally ill, once predominantly the responsibility of State mental hospitals, now occurs in diverse settings—medical and psychiatric, inpatient and outpatient, public and private. Profound changes in the funding, philosophy, and technology of mental health care have contributed to this transformation. The deliberate shift from mental hospital-based inpatient care to community-based outpatient care occurred through the process known as "deinstitutionalization."

For patients with severe mental illness, the results of this process have been a mixed blessing. Many patients fortunate to have or find adequate human and financial resources to help them cope with the many demands of community living have carved out successful lives outside of institutional settings. Others have simply moved from one inpatient environment (a mental hospital) to another (a nursing home). Still others live precariously in the community, alternating between short stays in medical and psychiatric institutions and a marginal community life marked by maladaptation and misery, unable to obtain rudimentary resources such as shelter, food, and health care. To understand the issues surrounding the latter group—many of whom now appear among the rolls of the homeless—it is important to understand how the historical process of deinstitutionalization occurred, and how its complex intended and unintended effects on the severely mentally ill arose.

A number of factors coalesced to bring about deinstitutionalization, including mass-media exposes on conditions in State hospitals, advances in mental health treatment, shifts in treatment philosophy, changes in the legal rights of mentally ill persons, and incentives to States to shift more of the costs of mental health treatment to the Federal Government.

Conditions in State Mental Hospitals

In the 1940s, journalists began to expose inhumane conditions in overcrowded and understaffed State mental hospitals (Deutsch, 1948; Gorman, 1948). At that time, sedation and restraints were used more often than necessary, and little active therapy was available to hospital residents. The custodial nature of care made many hospitals seem more like prisons than therapeutic havens. Reform-minded professionals and lay persons alike began to perceive these institutions as inherently

detrimental to patients, and they looked for ways to improve hospital conditions and create better treatment alternatives (Foley and Sharfstein, 1983; Goffman, 1961).

Advances in Mental Health Treatment and Shifts in Treatment Philosophy

Spurred by these reformers and by the concurrent development of new mental health treatment technologies in the 1950s, especially the advent of antipsychotic medication, a shift in values began that stimulated the transition to community-based mental health care. This new approach is commonly known as the "community mental health movement."

The new drug treatments controlled severe symptoms and offered the potential of enabling a large proportion of mentally ill individuals to live successfully outside of the mental hospital. There was also a simultaneous focus on creating a "therapeutic milieu" inside the hospital. Mental health professionals began slowly to alter their perceptions of all mentally ill persons as hopelessly, permanently disabled. Public education campaigns by the National Institute of Mental Health, which was established by the National Mental Health Act of 1946, also stimulated a change in people's attitudes toward mentally ill individuals.

The Community Mental Health Centers Act, passed by Congress in 1963, provided Federal funding for the construction and staffing of comprehensive community mental health centers (CMHCs), providing outpatient, inpatient, emergency, consultation, and partial hospitalization services for all persons living in defined "catchment" areas. This Federal seed money for community mental health services was another major stimulus to deinstitutionalization. However, only 768 of the 1500 CMHCs originally envisioned across the country were ever funded, and it is estimated that only 737 of these are still operating.

Changes in Legal Rights of Mentally Ill Persons

New treatment technologies, criticism of conditions in State hospitals, and changing attitudes about mental health care also stimulated changes in the laws concerning the rights of mentally ill persons. Toward the end of the 1960s, some courts began to affirm a right to treatment (rather than just custodial care) on the basis of State statute or the United States Constitution (see, for example, Rouse v. Cameron, and Wyatt v. Stickney). Other courts (e.g., New York State Association for Retarded Children v. Carey), however, did not go this far, but recognized a right to protection from harm, including deterioration of one's condition due to neglect. The U.S. Supreme Court has not recognized a Constitutional right to mental health treatment; however, in Youngberg v. Romeo (1982) it held that institutionalized mentally retarded persons had a Constitutional right to "minimally adequate or reasonable training," if that training would assist them in becoming more independent.

Many courts also began to recognize the right, based on State statutes, to mental health services provided in the least restrictive setting possible

(see, for example, Dixon v. Weinberger), and some courts overturned broad civil commitment laws that permitted indefinite hospitalization of mentally ill persons simply because they needed treatment (see, for example, Lessard v. Schmidt). In response, State legislatures began to pass laws that required that persons be mentally ill and dangerous to themselves or others before they can be involuntarily committed.

Shifting of State Costs to the Federal Government

Another significant spur to deinstitutionalization in some States was the desire to reduce the costs of mental health treatment borne by the States. The creation of the Federal Medicaid program in the mid-1960s enabled States to transfer some costs of mental health care to the Federal Government by moving patients from State mental hospitals (not well covered under Medicaid) to nursing homes and to general hospitals for acute care. In addition, the Federal Supplemental Security Income (SSI) program, established earlier, provided income support to mentally ill persons living in the community. The Social Security Disability Insurance (SSDI) program, established in the early 1970s, provided income support to persons who had previously paid into the Social Security fund or who were beneficiaries of others who had contributed. The availability of SSI and SSDI funds made it feasible for many formerly institutionalized mentally ill persons to afford to live independently in the community.

Implementation of Deinstitutionalization

The main goals of deinstitutionalization were to reduce inappropriate and unnecessary hospitalizations and to expand the availability of community-based mental health and supportive services for mentally ill persons. Deinstitutionalization has been characterized by four trends: reduction in numbers of State hospital residents, diversion of patients away from State hospitals, decrease in average length of stay in inpatient mental health facilities, and expansion of community mental health and supportive services. Before examining these trends on a national scale, it is important to note that the process of deinstitutionalization has varied significantly from State to State in terms of its rapidity, timing, and planning, and in the extent and quality of community services available for mentally ill people. Therefore, generalizations from individual State data can be misleading and must be made with caution.

Reduction in Number of State Hospital Residents

The number of residents in public mental hospitals in the (then 48) States and the District of Columbia in 1950 was 512,501; by 1986 the number in the 50 States had fallen to 108,800, an 80 percent decrease (President's Commission on Mental Health, 1978, Table 3; National Institute of Mental Health, 1988). The rate of reduction of the resident public mental hospital population across all the States followed a pattern of acceleration and deceleration in five stages:

a) 1956-1965: annual decreases of 1 to 3 percent;
b) 1966-1971: annual decreases of 5 to 9 percent;
c) 1972-1976: annual decreases of 10 to 13 percent;
d) 1977-1985: annual decreases of 5 to 7 percent;
e) 1986-1987: annual decrease of 1 percent.

Until 1969, high rates of hospital discharge were partially offset by an increase in admission rates. After 1969, decreased admission rates, coupled with increased discharge rates, reduced the overall resident hospital population. State mental hospitals had fewer residents in 1986 (the most recent year for which data are available) than at any time since 1950 (National Institute of Mental Health, 1988).

The reduction in the number of State mental hospital residents has had only a modest impact on expenditures for State hospitals. Expenditures in constant dollars for all State hospitals decreased from $1,814,101,000 in 1969 to $1,659,287,000 in 1986, a 9 percent reduction (National Institute of Mental Health, 1987a, Table 2.12b).

Several factors have prevented State mental hospital costs from falling more dramatically than they have. Improved standards of care required by the Health Care Financing Administration for participation in the Medicaid and Medicare programs require State hospitals to have much higher staff-to-patient ratios than in the past. (These ratios are much higher now than they once were, and overcrowding of patients is much less frequent; however, if States chose to reduce budgets for State mental hospitals significantly, these improvements could be reversed.) The stability of hospital expenditures is also partially explained by the strength of hospital employee unions in opposing closure, scaling back, and consolidating hospitals.

Diversion

The second trend associated with deinstitutionalization is the diversion of severely mentally ill persons away from State mental hospitals. One aspect of diversion is the reduced use of State mental hospitals (as opposed to other inpatient treatment programs, such as those of general hospitals). Between 1955 and 1986 the number of episodes* of inpatient treatment in State hospitals decreased from 502 to 192 per 100,000 population (President's Commission on Mental Health, 1978, Table 2; National Institute of Mental Health, 1983). Taken alone, these figures can be misleading because the rate of inpatient mental health treatment across all types of inpatient facilities actually remained steady during this period: 795 inpatient episodes per 100,000 population in 1955, and 798 episodes per 100,000 in 1986 (unpublished survey data, Survey and Reports Branch, Division of Biometry and Applied Services, National Institute of Mental Health). Inpatient hospitalization occurs just as frequently today as it did 30 years ago; the locus of inpatient care has simply shifted--primarily from State mental hospitals to acute psychiatric wards of general hospitals.

*See definitions, Appendix A.

Another aspect of diversion is the reduced use of inpatient treatment in comparison with outpatient treatment. While per capita rates of inpatient treatment have remained constant, per capita rates of outpatient treatment have increased greatly. The rate of outpatient mental health treatment increased from 576 per 100,000 population in 1969, to 1,175 per 100,000 population in 1986—more than a 100 percent increase.

Yet, many severely mentally ill, deinstitutionalized persons did not receive outpatient mental health services after their discharge or diversion from the hospital. Rather, most of the recipients of expanded outpatient mental health services were new patients with less severe, acute mental health problems.

Severely mentally ill persons were not a priority population for many community mental health centers in the 1960s and 1970s; as a result, this population did not participate to a great extent in the expansion of outpatient services. Therefore, while in the aggregate there was diversion from inpatient to outpatient services, many severely mentally ill persons were frequently diverted from inpatient care without appropriate care in the community. Since the establishment of the National Institute of Mental Health Community Support Program in 1977 and the Alcohol, Drug Abuse, and Mental Health Block Grant program in 1981, States and community mental health centers have intensified their focus on community services for severely mentally ill persons (Larsen and Jerrell, 1986).

Decrease in Length of Stay

The third trend associated with deinstitutionalization is the decrease in average lengths of stay in inpatient facilities. In 1969, State mental hospitals provided an average of 175 days of care per treatment episode, and general hospitals provided an average of 12 days of care per episode for psychiatric disorders. By 1986, State mental hospital stays averaged 85 days per episode, and those in general hospitals averaged 14 days, only a slight increase offsetting the dramatic 51 percent reduction in State hospital days (National Institute of Mental Health, 1987a, Tables 2.4 and 2.5). The average number of days per episode across all types of mental health inpatient facilities (including State mental hospitals, private psychiatric hospitals, general hospitals, Veterans Administration psychiatric services, inpatient wards of community mental health centers, and residential treatment centers for emotionally disturbed children) fell from 99 days in 1969 to 37 days in 1986 (see citation above).

Expansion of Community-based Mental Health Services

The fourth trend associated with deinstitutionalization is the expansion of community-based mental health services and of expenditures for these services. In 1955, approximately 379,000 episodes of outpatient mental health care were provided, while there were almost 1.3 million episodes of

inpatient psychiatric care (President's Commission on Mental Health, 1978). By 1986, episodes of outpatient care had risen to almost 5.6 million, while episodes of inpatient care had increased moderately to 1.9 million.

The expansion of community-based mental health services is reflected in expenditures. Overall mental health expenditures (Federal, State, local, and private) increased from $3.3 billion to $4.9 billion in constant dollars from 1969 to 1986 (National Institute of Mental Health, 1987a, Table 2.12b). Increased expenditures for non-inpatient and community residential mental health services (from $390 million in 1969 to over $1.1 billion in 1986) comprised about 44 percent of this increase.

Despite the overall expansion of financial support for community-based mental health services, however, most State resources are still devoted to institutional services. In 1985, 17 States allocated 70 percent or more of their mental health budgets to inpatient care, and only 7 States allocated less than half of their mental health budgets for inpatient services (National Association of State Mental Health Program Directors, 1987).

In summary, deinstitutionalization has involved far more than the simple release of hospital patients into the community. Reduced admissions to State mental hospitals have been offset by increased admissions to general hospitals. Although per capita rates of inpatient treatment have remained constant, per capita rates of outpatient treatment have increased considerably. In addition, psychiatric inpatients tend to have shorter lengths of stay in institutions today, whether those be State mental hospitals or general hospital psychiatric services. This means that at any given time, most severely mentally ill persons are living in the community. Many of them are receiving community-based mental health services. Unfortunately, many are not. The following section describes some of the successes and problems in the implementation of deinstitutionalization, including the shortage of community-based mental health care.

Successes and Problems in Implementing Deinstitutionalization

The shift from an institution-based to a community-based mental health system has been positive in many respects. Assisted by psychotropic medications, other treatment and services, and/or support from family or friends, many severely mentally ill persons are able to live successfully outside of mental hospitals. Even when mentally ill individuals require emergency hospitalization, their stays are usually much shorter than they once were. In addition, conditions in most State mental hospitals have improved greatly; overcrowding and understaffing are no longer as severe as they were 30 to 40 years ago. Consequently, patients receive more personalized attention than in the past. The development of individualized treatment plans for inpatients is now mandated in many State hospitals.

Many severely mentally ill persons require more than medication, therapy, and personal supports in order to live successfully in the community. They may also require, for example, community crisis-response services, supportive housing, assistance with daily living tasks, or vocational training. Over the past 20 years, there has been a proliferation of community-based mental health programs. Many of these models have proven effective in reducing symptomatology and improving functioning (see Kiesler, 1982; Braun et al., 1987).

In the Fairweather Lodge Program (Fairweather et al., 1969), for example, mentally ill individuals who lived together in a group home and ran a cooperative business were able to remain in the community longer than were similar patients who received only outpatient treatment. Similarly, Stein and Test (1985) found that the Wisconsin Training in Community Living (TCL) model, which features assertive provision of intensive treatment and support in the community, was very successful in stabilizing severely mentally ill persons in the community; these patients had very low hospital utilization rates. Stein and Test found that the TCL model greatly reduced hospital admissions and eliminated the "revolving door syndrome" of repeated, brief hospitalizations, while greatly improving individual quality of life.

Other nontraditional community-based mental health programs include home care, foster care, supervised apartment living, board-and-care homes, and self-help programs (see, for example, Fenton et al., 1979). Effective community programs seem to provide severely mentally ill clients with "ongoing, rather than time-limited, care and support," and "assertive individualized treatment" (Salem et al., 1988).

Although there are many demonstrably effective community-based models of mental health care, such services are not widely available in all communities. Most communities lack an adequate range of supported housing options and suffer from a lack of coordination among social service agencies. This fragmentation of the service system presents a daunting problem to severely mentally ill persons who may have trouble negotiating a complex bureaucracy. Each of these problems will be discussed in turn.

Lack of Appropriate Community-based Mental Health Services

Community mental health centers (CMHCs) were frequently not provided with incentives to serve long-term, severely mentally ill persons. Many CMHC employees were neither trained to work with severely mentally ill clients nor interested in serving them (Price and Smith, 1983). Rather, many CMHCs emphasized acute (short-term) mental health care and preventive services for mildly disabled individuals (Bachrach, 1979). Few severely mentally ill individuals have had access to intensive, long-term community-based treatment programs such as the Fairweather Lodge or the TCL programs.

Shortage of Adequate Housing Options

There is a paucity of housing alternatives for severely mentally ill persons (U.S. Department of Health and Human Services and Department of Housing and Urban Development, 1983 Lipton and Sabatini, 1984; Bachrach, 1979). Such alternatives should include staffed transitional housing programs, foster care, group homes, shared apartments, and independent housing (U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development, 1983).

In the absence of appropriate specialized residences, many mentally ill persons were discharged or diverted from State mental hospitals to nursing homes. Between 1969 and 1974, the number of nursing home residents with mental impairments increased 48 percent, from 607,400 to 809,500 (U.S. General Accounting Office, 1977). Of these patients, 37 percent received a primary diagnosis of mental illness or retardation. Nursing home placement was beneficial for many patients who needed physical nursing care or close supervision. However, it was inappropriate for many others, who needed neither medical care nor intensive assistance with activities of daily living.

Moreover, because of financial disincentives in the Medicaid program, nursing homes have tended not to provide the full level of mental health care needed by their residents (Goldman, Feder, and Scanlon, 1986; National Institute of Mental Health, 1984). Subtitle C of Public Law 100-203, the Nursing Home Reform Act of 1987, now mandates comprehensive mental health screening for nursing home residents and new admissions, the development of individualized plans of care, and the provision of appropriate services or discharge to a more appropriate program in the community.

The creation by the Social Security Administration of the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs, which provide disabled individuals, including the severely mentally ill, with a steady monthly income, acted as an incentive for the development of board-and-care homes. Nationwide, approximately 300,000 to 400,000 severely mentally ill patients now reside in board-and-care homes (U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development, 1983). Many patients were fortunate to find clean, well-maintained, and supervised facilities. However, some board-and-care homes were poorly run and maintained, and custodial rather than therapeutic (Lamb, 1984; Dittmar and Smith, 1983). In 1976, Congress passed the Keys Amendment (Public Law 94-566), which required States to create and enforce minimum standards for facilities receiving SSI funds (see also U.S. Department of Health and Human Services, 1982).

Still other severely mentally ill persons left hospitals for single room occupancy (SRO) units. One study found that 55 percent of patients discharged from a psychiatric hospital in New York went to live in SRO hotels (New York State Department of Mental Hygiene, 1979). Traditionally, SROs have been one of the lowest cost housing alternatives available to persons of marginal economic status, including a large

segment of the severely mentally ill population. However, the demolition and conversion of many SROs during the past several years have left many former residents homeless. (This topic receives further attention in Section IV of this report.)

Lack of Coordination of Services

In addition to providing treatment and housing, mental hospitals generally provided food, clothing, health care, social services, and personal support. In most communities, however, severely mentally ill persons and their families have had to negotiate complex bureaucracies to meet even their basic subsistence needs. Not surprisingly, many have been unable to accomplish this task. Only recently has there been increased attention to the need for "case management," defined as "a method of fixing responsibility for systems coordination with one individual, who works with a given client in accessing necessary services" (Levine and Fleming, 1984; see also Rog et al., 1987, and Intagliata, 1982). A case manager can only perform this function successfully, however, if the needed services are available; often they are not.

Public Law 99-660, the Comprehensive State Mental Health Planning Act, addresses some of these problems by mandating that each State develop a comprehensive plan for providing community-based mental health and related support services for all long-term, severely mentally ill persons. The Act specifically requires that case management be provided to all severely mentally ill persons receiving substantial amounts of public funding and that specialized services for homeless mentally ill persons be incorporated into the plan.

In addition, the National Institute of Mental Health Community Support Program (CSP), established in the late 1970s, awards competitive grants to States to demonstrate and evaluate effective community services to assist severely mentally ill persons in meeting their multiple mental health, housing, and support needs (Stroul, 1988; Turner and TenHoor, 1978; Turner and Shifren, 1979).

In summary, although the concept of deinstitutionalization was sound, its implementation was flawed in many respects. The comprehensive community-based mental health system that was to accompany the massive reduction of State mental hospital rolls has never fully materialized. Before examining the relationship of these shortcomings to homelessness among mentally ill persons, however, it is important to examine the general problem of homelessness.

III. HOMELESSNESS

Like deinstitutionalization, homelessness is a complex phenomenon. Almost no valid data exist on the size of the homeless population in the United States or on the causes of homelessness. However, a review of the research literature does provide a sense of the problem's broad dimensions (Burt and Cohen, 1989; Institute of Medicine, 1988; Rossi, 1989; Wright and Weber, 1987).

Number of Homeless People in the United States

In 1988, the U.S. General Accounting Office (GAO) reported that an accurate national estimate of the size of the homeless population is not available. The GAO documented the many methodological barriers to counting this population and summarized and compared the imprecise studies that are available (U.S. General Accounting Office, 1988).

Estimates of the number of persons in the United States who are homeless on a given night vary widely. A reliable estimate, from a 1988 Urban Institute study, is that approximately 567,000 to 600,000 persons are homeless on any given night (Burt and Cohen, 1989). The 1990 U.S. Census will survey the homeless in shelters and will conduct a one-night street count of the homeless population; this effort should yield more reliable data on the numbers of Americans who are homeless.

Service Needs of Homeless People

Homeless people are socially diverse and have multiple problems and service needs. Three descriptive research studies supported by NIMH between 1983 and 1986 compared the homeless population with the general population in Baltimore, Los Angeles, and the State of Ohio (Fischer et al., 1986; Farr et al., 1986; Roth et al., 1985; see also Tessler and Dennis, 1989).

In all three studies, homeless people tended to be younger than nonhomeless people. Minority group members were overrepresented among the homeless population in each site; for example, in Los Angeles, 73 percent of homeless people were minorities, compared with only 42 percent of the nonhomeless population. Other findings of note were the following:

- Homeless people were less likely than other people to have completed high school or to be currently employed, and they were more likely to receive public assistance benefits and to be veterans.

- Homeless people reported more physical health problems—but had much less health insurance—than nonhomeless people. Significantly more homeless people in Los Angeles had alcohol and/or drug problems, and in Baltimore, mental health and/or

substance abuse problems were nearly twice as prevalent among the homeless population as among the general population.

- Differences in social supports were striking between homeless and nonhomeless people. Among the homeless people in the Ohio study, 45 percent had never married (vs. 25 percent of the general population), 68 percent had no relatives they could count on for help (vs. only 8 percent of nonhomeless people), and 58 percent reported that they had no friends (vs. only 5 percent of the general population).

Factors Contributing To Homelessness

Homeless people report a wide range of reasons for their homelessness, including the lack of affordable housing, poverty, the fragmentation of services, and the lack of personal and social supports (Tessler and Dennis, 1989). These factors are discussed below.

Lack of Affordable Housing

The most obvious factor contributing to homelessness is a lack of affordable housing. Over the past decades, gentrification of many urban neighborhoods has eliminated many of the housing options once available to indigent and severely mentally ill individuals. Between 1970 and 1980, approximately 1 million single-room occupancy (SRO) units—almost one-half of the Nation's total—were converted to other uses or destroyed (Levine and Stockdill, 1986). A study by the New York City Human Resources Administration (1980) found that almost half of city shelter clients (45 percent) cited SROs and cheap lodging houses as their previous residence. Between 1970 and 1983, the number of single-room units in New York City decreased from 127,000 to 14,000 (Coalition for the Homeless and SRO Tenants Coalition, 1985). The continuing deterioration of public housing units also contributes to the shortage of affordable housing.

One measure of risk for becoming homeless is the proportion of one's income devoted to housing. The U.S. Department of Housing and Urban Development considers any family spending more than 50 percent of its income for housing to be at risk for homelessness. Preliminary tabulations from the 1985 American Housing Survey show that while only about 6 percent of U.S. households spend more than half of their income on housing, almost 48 percent (6.3 million) of households below the poverty line do so. Of these 6.3 million, over 4.4 million spend more than 70 percent of their income on housing.

Dolbeare (1988, Table A-2) estimates that in 1970 there was a surplus of 1.2 million housing units that were affordable (at 30 percent of income) to households with incomes under $5,000 (measured in 1983 dollars), and a surplus of 3 million units that were affordable to households with incomes under $10,000. By 1983, there was a shortfall of 2 million units for households with incomes under $5,000, and a shortfall of 1.4 million units for households with incomes under $10,000.

Poverty

A second major factor contributing to homelessness is poverty. While the percentage of Americans living below the poverty level has decreased each year since the peak of 15.2% in 1983, the decline in recent years (since 1986) has been minimal. The estimate of 31.1 million persons living below the poverty level in 1988 follows a plateau in this rate beginning in 1986 (Bureau of the Census, 1989). This stabilization can be attributed, in part, to unemployment and changes in the structure of the work force, especially the shift away from semi-skilled industrial jobs toward low-paying, unskilled jobs in the service sector. In 1979, the national unemployment rate was 5.8 percent; by 1982, the rate had climbed to 9.7 percent (Bureau of Labor Statistics, 1988). The unemployment rate has decreased since then to 5.5 percent in 1988; however, despite this general improvement it is extremely difficult for homeless individuals who may lack an address, telephone number, and appropriate clothing, to compete for and retain jobs. A 1986 Ohio Department of Mental Health study of the housing needs of mentally ill people revealed that most exist on a median income of $3,000 per year.

During the late 1970s and 1980s, the real value of many entitlement benefits declined. Median benefits through the Aid to Families with Dependent Children (AFDC) program, for instance, declined by about one-third in real dollars between 1970 and 1985 (U.S. House Committee on Ways and Means, 1987). While one report (Congressional Research Service and Mathematical Policy Research, 1984) linked reductions in Federal spending to increases in poverty, no information is available linking these reductions to increased homelessness (U.S. General Accounting Office, 1985).

Fragmentation of Services

A third factor contributing to homelessness is the fragmentation of services. Even homeless persons without mental illness often have difficulty negotiating complex bureaucracies to obtain housing, health care, employment, income support, and social services. No single program provides all of these services; just learning about them, let alone applying for them, can be a great challenge.

The application process for public assistance presents many potential problems for homeless persons. For example, these individuals may not have identification because their personal belongings have been stolen or lost. Many homeless persons lack any means of transportation to the eligibility office. Still others do not speak English and do not know anyone who can assist them in applying.

Until 1986, homeless persons could not apply for entitlement benefits unless they could provide an address. However, the Homeless Eligibility and Clarification Act of 1986 eliminated the address requirement for entitlements. Now homeless persons may use a shelter or a post office box as the destination for their checks.

Lack of Supports

A fourth major factor contributing to homelessness is a lack of personal and social supports. Indigent persons who do have such supports may be able to find at least temporary housing with relatives or friends. They also may be able to borrow money and to rely on family or friends for emotional sustenance. While people in this situation may be living on the brink of homelessness, they do have some resources to call upon.

Homeless people, by contrast, are more likely to lack such resources, or to have exhausted them (Tessler and Dennis, 1989). Relatively little research to date has focused on the causal relationship between weak personal and social ties and homelessness. Social isolation may be either a cause of homelessness or a result of the stigma accompanying homelessness; most homeless persons probably experience some mixture of the two.

IV. THE RELATIONSHIP OF DEINSTITUTIONALIZATION TO HOMELESSNESS

The relationship between deinstitutionalization and homelessness is extremely complex and difficult to analyze. Longitudinal follow-up data on mentally ill persons who were either discharged or diverted from mental hospitals are not widely available. Statistics regarding numbers of patients discharged and diverted tell little about which patients these were, where they went, and how they fared. Likewise, although one-time interviews with homeless persons may yield information on their present mental condition and perhaps on the reasons for their homelessness (which are usually multiple and complex in themselves), they explain little about the similarities and differences between homeless mentally ill persons and other mentally ill persons who are not homeless.

More definitive information concerning these issues may be forthcoming through research proposals submitted in response to a December 1988 grant announcement by the National Institute of Mental Health entitled "Research and Research Demonstrations on Homeless Severely Mentally Ill Adults and Homeless Families with Children Who Are at Risk of Severe Emotional Disturbance." (These grants will focus on epidemiological research, services research, and service systems research.)

This section will first discuss the proportion of the homeless population with mental illness and the reasons for homelessness among mentally ill individuals. It concludes with an analysis of the extent to which deinstitutionalization may have contributed to homelessness among some mentally ill individuals.

Prevalence of Severe Mental Illness among the Homeless

Findings from ten studies supported by NIMH between 1983 and 1986 suggest that approximately one-third of the homeless population suffers from severe and disabling mental illnesses such as schizophrenia, manic-depressive illness, or severe depression (Tessler and Dennis, 1989). These studies (Morrissey and Dennis, 1986) as well as several more recent ones (Sosin, 1988; Piliavin, 1988) suggest that approximately one-fourth of homeless persons have had psychiatric hospitalization in the past. These segments of the homeless population do not overlap completely; many homeless mentally ill persons have never had psychiatric hospitalization, and many formerly institutionalized homeless persons are not currently in need of mental health services (Morrissey and Dennis, 1986).

Factors Contributing to Homelessness among Severely Mentally Ill People

Like all homeless people, those who are mentally ill and homeless report many reasons for their homelessness, including the lack of affordable housing, poverty, fragmentation of services, and lack of supports. Severe mental illness is often just an additional factor that places one at high risk of homelessness (Levine et al., 1986).

Lack of Affordable Housing

Severely mentally ill people frequently have a marginal economic status. Disability income or sporadic employment may constitute their only source of support, making it extremely difficult to secure and retain affordable housing. Periodic hospitalization may add to the difficulty of keeping one's housing.

Many mentally ill people have historically lived in marginal housing alternatives such as rooming houses and single room occupancy hotels (Levine and Stockdill, 1986). They are an extremely vulnerable group and may have been affected even more than other indigent populations by the depletion of this housing stock. Mentally ill and formerly hospitalized persons are often victims of discrimination by landlords and neighbors.

Poverty

Because a substantial proportion of severely mentally ill persons do not hold a job (Tessler et al., 1982), they are more likely to be affected by reductions in public assistance benefits than by reductions in employment opportunities. Supplemental Security Income (SSI) benefits support approximately one-half of those persons with severe, disabling mental illness (Newman and Struyk, 1987). Although, unlike other public assistance programs, SSI benefits have not declined in real value, they have not kept pace with rapidly escalating housing costs. In many cities it is impossible to find an apartment or even an SRO unit that costs less than an SSI monthly payment.

In 1980, Congress amended the Social Security Act to require periodic reviews of SSI recipients to determine their current need for disability income. Between 1981 and 1982, many mentally ill persons, although unable to work, lost their SSI benefits--often because they were too ill to contest the ruling (Koyanagi, 1985). Of those mentally ill individuals who appealed their benefits termination, 91 percent later had their benefits reinstated (U.S. House Committee on Ways and Means, 1983). During the termination period, however, many mentally ill persons were without income support of any kind, and some may have become homeless.

Fragmentation of Services

Severely mentally ill homeless persons are often unable to obtain needed services. In addition to the problems all homeless persons face in applying for housing, benefits, and services, those who are also mentally ill often confront additional obstacles. They may be especially vulnerable to stress and unable to cope during a time of crisis. They may also be stigmatized by service providers who prefer to serve less disabled clients.

It is important to note that most homeless mentally ill persons are willing to accept assistance (Morse et al., 1985). However, service providers' perceptions of these clients' needs often differ from those of the clients themselves (Morrissey and Dennis, 1986). A recently completed

synthesis of ten NIMH-sponsored descriptive research studies indicates that clinicians tend to focus on the need for mental health treatment, while homeless mentally ill people tend to emphasize the lack of basic housing and social supports. These differences in priorities may be wrongly interpreted by service providers as resistance to receiving help.

For these reasons, mental health interventions must be adapted to the special needs of homeless mentally ill persons. The Stewart B. McKinney Homeless Assistance Act recognized the need for specialized mental health services when it required grantees to provide outreach and case management to homeless mentally ill persons. Outreach may be defined as "a service which increases the access of a homeless mentally ill individual to other needed treatments and services" (Axleroad and Toff, 1987). Outreach is often mobile—that is, outreach workers contact homeless, mentally ill individuals on the streets, in shelters, soup kitchens, or day programs. Outreach programs typically focus on meeting clients' immediate subsistence needs, as well as their mental health needs.

Intensive, long-term case management is also needed to assist homeless mentally ill persons in addressing their multiple needs. Intensive case management "involves a comprehensive, aggressive approach to accessing and securing basic, health, and mental health services for seriously mentally ill individuals who are 'most in need'—individuals considered at risk of hospitalization, who lack both an adequate support system and independent living skills, and who either cannot or will not access services on their own" (Rog et al., 1987).

Lack of Supports

People with severe mental illness tend to have fewer family and social supports than people without mental illness, and the paucity of such supports probably contributes to homelessness. Although no research is available to document a causal relationship, some studies do suggest an association between lack of support and homelessness (Bassuk and Rosenberg, 1988; Fischer et al., 1986). The NIMH-supported study of the homeless in Los Angeles found that homeless mentally ill persons had even more impoverished social supports than other homeless persons; those who were mentally ill and homeless were less likely to be in contact with family or friends and more likely to have poor relations with their family (Tessler and Dennis, 1989).

In summary, due to marginal economic status, difficulty with tasks of daily living, vulnerability to stress, or crisis episodes that may require brief hospitalization, severely mentally ill persons face an elevated risk of homelessness. Furthermore, once they become homeless, their illness can complicate their many problems.

V. CONCLUSIONS CONCERNING THE RELATIONSHIP BETWEEN [redacted] AND HOMELESSNESS

Despite the paucity of longitudinal data on severely mentally ill persons who were discharged or diverted from State hospitals, it is possible to make the following general observations concerning the extent to which the deinstitutionalization policies of the States may have contributed to homelessness:

1. **Deinstitutionalization was not a primary cause of homelessness in general.**

Approximately one-third of the adult homeless population suffers from severe mental illness (Teesler and Dennis, 1989). Two-thirds of the homeless population are not severely mentally ill, and deinstitutionalization bears no relationship to their homelessness. Rather, their homelessness stems from other factors, including the shortage of affordable housing, poverty, fragmentation of services, and the lack of personal and social supports.

2. **Most deinstitutionalized, severely mentally ill persons are not homeless.**

While few statistics are available to document the residential histories of persons who were actually discharged or diverted from mental hospitals, the number of deinstitutionalized persons far exceeds any reasonable estimate of the number of homeless mentally ill persons. The national end-of-the-year State hospital population census alone dropped by about 400,000 between 1950 and 1986. Because this figure does not include the large numbers of mentally ill individuals who were hospitalized and released during the course of these years or who were diverted from State hospitals, it vastly underestimates the number of persons who were "deinstitutionalized." Assuming that one-third of the homeless population suffers from severe mental illness and using the Urban Institute's middle-range estimate of 600,000 homeless persons (Rich, 1988), there would be about 200,000 homeless mentally ill persons in this country on any single day. Although definitive counts are not available for either deinstitutionalized or homeless mentally ill persons, the former far outnumber the latter.

3. **Deinstitutionalization contributed to homelessness among some severely mentally ill persons.**

Deinstitutionalization undoubtedly contributed to the homelessness of some severely mentally ill persons to the extent that they were discharged or diverted from State mental hospitals to communities without comprehensive mental health services and residential supports. Although there are many models of effective community-based mental health and support services, the need for these services far exceeds the supply.

This is not to say that all homeless mentally ill persons are homeless solely because of their discharge or diversion from a mental hospital. Generally speaking, the causes of homelessness cited by severely mentally ill persons are identical to those cited by other homeless persons: lack

of affordable housing, poverty, inadequate services, and poor social and personal supports. Mental disability, like physical disability, alcoholism, an abusive relationship, or old age, may simply place one at higher risk of losing one's housing or employment and may impede one's ability to cope with crises.

The period of highest State hospital discharge rates (1972-1976) long preceded the emergence of homelessness as a widespread crisis attracting media coverage and heightened public awareness in the 1980s. Until the 1980s, homeless mentally ill persons were not especially visible on city streets and in shelters. Presumably, this is because many of these released patients were able to find at least marginal housing or live with family or friends. The deterioration and disappearance of affordable housing, the persistence of poverty, and the breakdown in services and supports may have stretched those living at the margin beyond their means and forced them onto the streets.

4. **"Reinstitutionalization" will not solve the problem of homelessness in general or among mentally ill persons. In fact, reinstitutionalization is inappropriate for most homeless mentally ill persons.**

"Reinstitutionalization," or the mass return of severely mentally ill persons to mental hospitals, has been heralded as a solution to the problem of homelessness. This recommendation is flawed, however. Since mentally ill persons comprise only about one-third of the homeless population, even the rehospitalization of all homeless mentally ill individuals would not eradicate the problem of homelessness.

The real precipitating causes of homelessness, even among the mentally ill, seem to be the lack of affordable housing, the persistence of poverty, the fragmentation of the social welfare system, and the breakdown in personal and social supports. Any solution to the problem of homelessness must address all of these causes in order to be effective.

Rehospitalization is not medically necessary for most severely mentally ill and homeless persons (U.S. Department of Health and Human Services, 1980). The medications and therapies that spurred deinstitutionalization in the first place make it possible for most severely mentally ill persons to live in the community if provided with adequate supports. This is not to say that hospitalization has no place, especially for patients in acute stages of severe mental illness. A small proportion of mentally ill persons do need supervised care in inpatient settings. However, current law appropriately protects mentally ill persons from unnecessary hospitalization. A return to long-term custodial care is both clinically and legally inappropriate when treatment and supports can be made available in the community where patients can participate fully in community life (Kiesler, 1982; Braun et al., 1981).

Contrary to popular stereotypes, research shows that most severely mentally ill, homeless persons do not want to be homeless and that they are willing to accept assistance if offered in an appropriate manner (Morse et al., 1985). Comprehensive community-based mental health and

support services and residential assistance, rather than rehospitalization, are needed to reduce homelessness among severely mentally ill persons.

In summary, the extent to which deinstitutionalization has actually contributed to homelessness is not known. To the extent that multiple factors (e.g., poverty, insufficient affordable housing, fragmented services, and insufficient community supports) are usually involved in a person's becoming homeless, even the most extensive research on homelessness may not quantify precisely the relative contribution of deinstitutionalization to homelessness as opposed to the contribution of these other factors.

VI. FEDERAL INITIATIVES ON BEHALF OF HOMELESS MENTALLY ILL PERSONS

A wide range of Federal programs provide assistance to homeless mentally ill persons and severely mentally ill persons at risk of homelessness. This section touches very briefly on the most relevant Federal programs that are available to all indigent persons, then focuses upon mental health initiatives, followed by programs for the homeless mentally ill. This section also examines some problems with these current Federal initiatives and the status of relevant research.

Housing and Entitlement Programs

A thorough discussion of social welfare programs available to homeless and mentally ill persons goes far beyond the focus of this report. However, several important areas of Federal involvement merit special mention, as follows:

The Medicaid program provides Federal reimbursement for health and mental health care to indigent persons. Medicaid mental health coverage is limited. It only covers psychiatric inpatient services in general hospitals, not State or private freestanding psychiatric hospitals, for patients between the ages of 22 to 64. Medicaid also covers unskilled nursing home care for destitute patients of all ages; this coverage has given States an incentive to transfer mentally ill patients to nursing homes where they often do not receive the treatment they need, because it is not reimbursable. The Nursing Home Reform Act of 1987 is an attempt to discourage inappropriate placement of mentally ill persons in nursing homes by mandating a mental health screening process. Mentally ill persons who do not require nursing care will be denied admission to nursing homes. It is unclear, however, where these patients will go instead; some will undoubtedly return to State mental hospitals.

The Medicaid program also offers a "Home and Community-Based Waiver" at a State's option. Under the waiver program, Medicaid reimburses long-term care, including mental health treatment, outside of a nursing home if the State shows that the care promises to be less costly than equivalent treatment inside a nursing home. As of 1986, only four States had been granted waivers for services for severely mentally ill persons (Toff and Scallet, 1986). The difficulty of demonstrating a cost savings acted as a disincentive, and consequently, many states refrained from applying for a waiver.

Under the Consolidated Budget Reconciliation Act of 1985, States were given the option of providing Medicaid reimbursement for case management in the community. More recently, Congress authorized States to reimburse outreach and other nontraditional mental health services provided outside the community mental health center. Both of these Medicaid reforms will improve the quality of care to severely mentally ill persons by reimbursing services that are more appropriate for this population.

The Social Security Administration operates two of the most important programs for disabled persons, including the mentally ill: the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. Persons who have paid into the Social Security fund or who are beneficiaries of such a person are eligible to receive SSDI; all others are eligible to receive SSI. SSDI and SSI are entitlement programs providing fixed disability benefits to mentally disabled persons who are unable to work. In most states, SSI eligibility makes one categorically eligible for Medicaid, and SSDI eligibility entitles one to Medicare coverage. Along with its State complement, sometimes known as "general assistance," SSI or SSDI may constitute a mentally ill person's only source of income. Unfortunately, SSI and SSDI payments have not kept up with housing costs in most cities, making it extremely difficult for recipients to obtain and maintain housing.

Until recently, SSI recipients lost their eligibility for benefits if they entered the hospital for brief treatment; sometimes reestablishing eligibility took several months, and individuals lost their housing in the interim. Until recently, SSI recipients also lost their benefits if they spent more than 3 months at an emergency shelter. Now homeless recipients may retain their SSI benefits for 9 months, which is still less time than it takes most homeless mentally ill persons to find housing.

Both SSI and SSDI place limits on the amount of external assistance a recipient may accept before losing benefits. If SSI recipients live with family members or friends, for example, their benefits are reduced by one-third. This penalty acts as a disincentive to share housing and increases recipients' risk of homelessness. Upon reaching a certain earnings level, SSI/SSDI benefits are revoked entirely, and along with them, Medicaid/Medicare eligibility. Since it is difficult for severely mentally ill persons to obtain private health insurance which covers a preexisting mental illness, SSI and SSDI recipients may be reluctant to work at all, because they could jeopardize the only health insurance available to them.

The U.S. Department of Housing and Urban Development (HUD) operates two housing assistance programs for persons with very low incomes. The Section 8 program provides rental assistance to landlords on behalf of eligible low income tenants. Residents pay up to 30 percent of their incomes toward the rent, and HUD will subsidize the rest of the rent, up to local fair market value. Most Section 8 assistance is available through the local housing authorities and allows tenants to locate apartments which meet their needs. If the resident chooses to move, the assistance can travel with them rather than remaining with the building. Some Section 8 assistance is tied to particular multi-family dwellings. When tenants leave the dwelling, the Section 8 assistance on that unit is retained for the next tenants.

The HUD Section 202 program is a Federal program to develop housing designed specifically for elderly and disabled persons, including severely mentally ill persons. The program provides low-interest, long-term loans for the construction or renovation of housing for these

populations, and reserves Section 8 certificates for each unit. The Section 202 program is designed to create large-scale congregate housing for the elderly, not the small, scattered-site housing that some believe is more desirable for mentally ill individuals (Ben-Dashan et al., 1982). In addition, the program does not place heavy emphasis on the provision of on-site supportive services. As a result, it has not been widely used for the mentally ill population.

Initiatives Targeted to Mentally Ill Persons

The Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant Program, which was established in 1981, provides formula grants to States for community-based mental health services. In 1988, $238.1 million were allocated to the States for this program, most of which will ultimately support comprehensive services at community mental health centers. Although there is no set-aside within the ADMS block grant program for services to severely mentally ill persons, this population is listed as a priority. The ADMS block grant permits the States broad discretion in the use of funds and imposes only minimal reporting requirements. As a result, it is difficult to know what proportion of ADM funds support services for long-term, severely mentally ill persons.

The National Institute of Mental Health Community Support Program (CSP) was established in the mid-1970s. CSP awards competitive grants to States to develop and demonstrate "community support systems" to assist severely mentally ill persons in meeting their multiple mental health, housing, and social support needs (Stroul, 1988; Turner and TenHoor, 1978; Turner and Shifren, 1979).

Public Law 99-660, the State Comprehensive Mental Health Services Plan Act of 1986, requires that States develop plans for "organized community-based systems of care," including case management, for severely mentally ill individuals, and that they submit an annual plan describing the implementation of such a system. The Act also requires that States plan for systematic outreach and other services to homeless mentally ill persons.

Initiatives Targeted to Homeless and Homeless Mentally Ill Persons

Public Law 100-77, the Stewart B. McKinney Homeless Assistance Act, authorized funding for a comprehensive range of services for the homeless. The Act included the following mental health provisions: Section 611 authorizes a Block Grant Program for Services to Homeless Individuals Who Are Chronically Mentally Ill. The block grant program is a noncompetitive grant program designed to provide States with funds for five services: outreach, case management, mental health treatment, support and supervisory services in housing for homeless mentally ill persons, and training for service providers. Block grant funds are allocated to all States and territories on a formula basis, weighted toward urban areas.

Section 612 authorizes a Community Mental Health Services Demonstration Program for Homeless Individuals Who Are Chronically Mentally Ill. This is a competitive grant program intended to encourage the development and evaluation of innovative services for homeless mentally ill persons. The FY 1987 appropriation of $9.3 million was used to fund 12 demonstration projects. Nine of the projects were designed to provide a comprehensive set of services to homeless mentally ill adults; three smaller projects focused on more discrete interventions for homeless families with children and youth at high risk of emotional disturbance. Each of the nine projects that serve homeless mentally ill adults was required to provide an array of services similar to those required by the block grant program. These services include: outreach; intensive, long-term case management; mental health treatment; staffing and operation of supportive living programs; and management and administrative activities.

Subtitle C of the McKinney Act authorized two new housing programs within HUD: the Transitional Housing Program and a program of Permanent Housing for Handicapped Homeless Persons. Funds were available on a competitive basis under both programs for acquisition or rehabilitation of buildings to be used as residences for "deinstitutionalized homeless individuals, homeless families with children, and homeless individuals with mental disabilities and other handicapped homeless persons." Funds were also available for operating costs under the transitional housing program.

Research on the Homeless Mentally Ill Population

Within NIMH, there has been a strong emphasis on research and evaluation as cornerstones for service development. As discussed earlier, between 1982 and 1986, NIMH sponsored 10 descriptive studies of the characteristics and service needs of the homeless mentally ill population. Currently, NIMH is conducting an implementation evaluation of the 12 community mental health demonstration projects established under the McKinney Act. In addition, in December 1988, NIMH announced the availability of funding in fiscal year 1989 for "Research and Research Demonstrations on Homeless Severely Mentally Ill Adults and Homeless Families with Children Who Are At Risk of Severe Emotional Disturbance." In coming years, NIMH plans to support investigator-initiated epidemiological and services research projects and additional research demonstrations that can contribute to more effective delivery of mental health and related services and treatment both to severely mentally ill homeless adults and to homeless families and children.

VII. ACTION STEPS

Our review of research on deinstitutionalization and its relationship to homelessness suggests that deinstitutionalization is only one of many factors contributing to homelessness among mentally ill persons. However, for the many reasons described earlier in this report, the mentally ill are overrepresented among the homeless.

Severely mentally ill individuals who are homeless require a range of housing and community support services in addition to mental health treatment. In our present system of care, responsibility for meeting these multiple needs is generally fragmented across different layers of Government, between the public and private sector, and among different health, mental health, housing, and other human service agencies. Our findings suggest, too, that Federal programs often inadvertently create barriers and financial disincentives to appropriate care.

Further steps that the Department of Health and Human Services intends to take as a result of this review, in order to provide leadership to assist States and communities to respond better to the needs of the homeless mentally ill, are:

- The Department of Health and Human Services will be announcing a new round of FY 1990 Mental Health Demonstration projects using McKinney Act and other PHS resources to improve treatment and care of severely mentally ill individuals who are homeless or at risk of becoming homeless; and

- The Department of Health and Human Services will be collaborating with HUD on programs and projects which combine Mental Health treatment with housing assistance.

In addition, the Department of Health and Human Services has accepted a recommendation from the Director of NIMH that a Task Force on Severe Mental Illness and Homelessness be formed to prepare a plan for Federal research to systematically examine:

- -The causes and prevention of homelessness among severely mentally ill persons;
- -The prevalence and types of major mental illnesses among the homeless population;
- -The causes and treatment of severe mental illness;
- -Effective approaches for providing treatments and coordinating services to severely mentally ill persons, including those who are homeless; and
- -Factors that impede access of severely mentally ill persons, particularly those among them who are homeless or at high risk of homelessness, to housing, mental health, income support, and human services programs.

Because of the importance of this issue, the Department of Health and Human Services will designate the Director of the National Institute of Mental Health to chair this Task Force on Severe Mental Illness and Homelessness, with assistance from the heads of the Health Care Financing Administration, and the Social Security Administration. Other participants will include representatives of HUD, DOL, and VA; State and local levels of government; non-profit providers and research organizations; and members of the private sector, who either finance, manage, or provide services to the homeless mentally ill.

Once accepted, the plan developed by the Task Force on Severe Mental Illness and Homelessness shall be forwarded to the Federal Interagency Council on the Homeless so that the Executive Branch can outline a course of action (including legislative proposals, regulations, and/or Executive branch programs) so that States and localities can better meet the housing, treatment, and support needs of severely mentally ill and homeless mentally ill persons.

The Stewart B. McKinney Homeless Assistance Act established the Federal Interagency Council on the Homeless to coordinate all federal programs for homeless persons, and provide technical assistance to states, local governments, and other public and private nonprofit organizations which are serving homeless persons. The Task Force on Severe Mental Illness and Homelessness will have a distinctively different mandate. It will focus not on homelessness broadly, but upon homelessness among severely mentally ill persons. By addressing the systemic problems that make severely mentally ill people particularly vulnerable to homelessness, this could help abate the growth of this sizeable segment of the homeless population.

VIII. REFERENCES

American Housing Survey (1985). As conducted by the U.S. Department of Housing and Urban Development.

Axleroad, S. and Toff, G. (1987). Outreach Services for Homeless Mentally Ill People. Rockville, Maryland: National Institute of Mental Health.

Bachrach, L. (1979). Deinstitutionalization: An Analytical Review and Sociological Perspective. Washington, D.C.: U.S. Government Printing Office. DHEW No. ADM-79-351.

Bassuk, E., and Rosenberg, L. (1988). Why Does Family Homelessness Occur? A case-control study. American Journal of Public Health, 78: 784788.

Ben-Dashan, T., Morrison, L.,, Kolter, M. and Jones, C. (1982). Exploratory Evaluation of the HUD/HHS Demonstration Research Deinstitutionalization of the Chronically Mentally Ill: Final Report. Silver Spring, Maryland: Macro Systems, Inc.

Birnbaum, M. (1960). The right to treatment. [redacted] a Journal 46: 499.

Braun, P., Kochansky, G., Shapiro, R., Greenberg, S., Gudeman, J., Johnson, S., and Shore, M. (1981). Overview: Deinstitutionalization of psychiatric patients: A critical review of outcome studies. American Journal of Psychiatry 138: 736-749.

Bureau of the Census. (1989) Money, Income, and Poverty Statistics in the United States, 1988. Washington, D.C.: Bureau of the Census.

Bureau of Labor Statistics. (1988). Employment and Earnings. Washington, D.C.: U.S. Department of Labor, p. 160.

Burt, M.R. and Cohen, B.E., (1989-3) America's Homeless: Numbers, Characteristics, and Programs that Serve Them. Washington, D.C.: The Urban Institute Press.

Coalition for the Homeless and SRO Tenants Rights Coalition (1985). Single Room Occupancy Hotels: Standing in the Way of the Gentry. New York: Coalition for the Homeless and SRO Tenants Rights Coalition.

Congressional Research Service and Mathematical Policy Research (1984). Effects of the Omnibus Budget Reconciliation Act of 1981 (OBRA) Welfare Changes and the Recession on Poverty. For the House Committee on Ways and Means, No. WMCP 98-33, July 25, 1984.

Deutsch, A. (1348). The Shame of the States. New York: Harcourt, Brace.

Dittmar, N.D., and Smith, G.P. (1983). Evaluation of Board and Care Homes: Summary of Survey Procedures and Findings. Denver: Denver Research Institute, University of Denver.

Dixon v. Weinberger, 405 P. Supp. 974 (D.D.C. 1975).

Dolbeare, C. (1988). Low-income housing crisis and its impact on homelessness. In: Advisory Commission on Intergovernmental Relations: Assisting the Homeless: State and Local Responses in an Era of Limited Resources. Washington, D.C.: Advisory Commission on Intergovernmental Relations.

Fairweather, G.W., Saunders, D.H., Cressler, D.L., and Maynard, H. (1969). Community Life for the Mentally Ill. Chicago: Aldine.

Farr, R., Koegel, P., and Burnam, A. (1986). A Study of Homelessness and Mental Illness in the Skid Row Area of Los Angeles. Los Angeles: County Department of Mental Health.

Fenton, P.R., Tessier, L., and Struening, B.L. (1979). A comparative trial of home and general psychiatric care: One-year follow-up. Archives of General Psychiatry 36: 1073-1079.

Fischer, P., Shapiro, S., Breakey, W., Anthony, J., and Kramer, M. (1986). Mental health and social characteristics of the homeless: A survey of mission users. American Journal of Public Health 76: 519-524.

Foley, H.A., and Sharfstein, S.S. (1983). Madness and Government: Who Cares for the Mentally Ill? Washington, D.C.: American Psychiatric Press.

Goffman, I. (1961). Asylums. Garden City: Anchor Books.

Goldman, H., Gattozzi, A., and Taube, C. (1981). Defining and counting the chronically mentally ill. Hospital and Community Psychiatry 32: 21-27.

Gorman, M. (1948). "Oklahoma Attacks Its Snake Pits". The Reader's Digest: 139-160.

Hombs, M.E., and Snyder, M. (1982). Homelessness in America: A Forced March to Nowhere. Washington, D.C.: Community for Creative Nonviolence.

Hopper, K., and Hamberg, J. (1984). The Making of America's Homeless: From Skid Row to New Poor. New York: Community Service Society.

Institute of Medicine. (1988) Homelessness, Health, and Human Needs. Washington, D.C.: National Academy Press.

Intagliata, J. (1982). Improving the quality of care for the chronically mentally disabled: The role of case management. Schizophrenia Bulletin 8: 655-674.

Kiesler, C.A. (1982). Mental hospitals and alternative care: Noninstitutionalization as potential public policy for mental patients. American Psychologist 37: 349-360.

Koyanagi, C. (1985). Social Security Disability Benefits Reform Act of 1984: Implications for those disabled by mental illness. Psychosocial Rehabilitation Journal 9: 21-31.

Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966).

Lamb, H.R. (1984). Deinstitutionalization and the homeless mentally ill. In: H.R. Lamb, (Ed.), The Homeless Mentally Ill. Washington, D.C.: American Psychiatric Press.

Larsen, J., and Jerrell, J. (1986). Factors Affecting the Development of Mental Health Services. Los Altos, California: Cognos Associates.

Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated and remanded al other grounds, 414 U.S. 473 (1974), redecided, 379 F. Supp. 1376 (E.D. Wis. 1974), vacated and remanded on other grounds, 421 U.S. 957 (1975), redecided, 413 F. Supp. 1318 (E.D. Wis. 1976).

Levine, I.S., and Fleming, M. (1984). Human Resource Development: Issues in Case Management. College Park, Maryland: Center of Rehabilitation and Manpower Services, University of Maryland.

Levine, I.S., Lezak, A.D., and Goldman, H.H. (1986). Community support systems for the homeless mentally ill. In: B. Bassuk (Ed.), The Mental Health Needs of Homeless Persons. San Fransisco: Jossey-Bass.

Levine, I.S., and Stockdill, J.W. (1986). Mentally ill and homeless: A national problem. In: B.E. Jones (Ed.), Treating the Homeless: Urban Psychiatry's Challenge. Washington, D.C.: American Psychiatric Press.

Lipton, F.R., and Sabatini, A. (1984). Constructing support systems for homeless chronic patients. In: H.R. Lamb (Ed.), The Homeless Mentally Ill. Washington, D.C.: American Psychiatric Press.

Morrissey, J.P., and Dennis, D.L. (1986). NIMH-Funded Research Concerning Homeless Mentally Ill Persons: Implications for Policy and Practice. Rockville, Maryland: National Institute of Mental Health.

Morse, G., Shields, N., Hamneke, C., Calsyn, R., Burger, G., and Nelson, B. (1985). Homeless People in St. Louis: A Mental Health Program Evaluation, Field Study, and Follow-up Investigation. Jefferson City: Missouri Department of Mental Health.

National Alliance to End Homelessness (1988). Housing and Homelessness. Washington, D.C.: National Alliance to End Homelessness.

National Association of State Mental Health Program Directors (1987). Final Report: Funding Sources and Expenditures of State Mental Health Agencies: Revenue/Expenditure Study Results Fiscal Year 1985. Washington, D.C.: National Association of State Mental Health Program Directors.

National Institute of Mental Health (1988a). Additions and Residents at End of Year, State and County Mental Hospitals by Age and Diagnosis, by State, U.S. 1986. Rockville, Maryland: National Institute of Mental Health.

National Institute of Mental Health. (1988b). "Research and Research Demonstrations on Homeless Severely Mentally Ill Adults and Homeless Families with Children Who Are At Risk of Severe Emotional Disturbance." Rockville, Maryland: National Institute of Mental Health.

National Institute of Mental Health (1987a). Mental Health, United States, 1987. R. Manderscheid and S. Barrett (eds.) Washington, D.C.: U.S. Government Printing Office. DHHS Pub. No. (ADM) 87-1518

National Institute of Mental Health (1987b). Toward a Model Plan for a Comprehensive, Community-Based Mental Health System. Rockville, Maryland: National Institute of Mental Health.

National Institute of Mental Health, Division of Biometry and Applied Sciences (1983). Published and unpublished inventory data from the Survey and Reports Branch. Rockville, Maryland: National Institute of Mental Health.

Newman, S., and Struyk, R. (1988). Housing and Supportive Services: Federal Policy for Frail Elderly and Chronically Mentally Ill. Cambridge, Massachusetts: Massachusetts Institute of Technology Center for Real Estate Development.

New York City Human Resources Administration (1980). Chronic and Situational Dependency: Long-Term Residents in a Shelter for Men. New York: New York City Human Resources Administration.

New York State Association for Retarded Children, Inc., v. Carey, 706 F.2d 956 (2d Cir. 1983).

New York State Department of Mental Hygiene, Bureau of Special Projects Research (1979). A Survey of Services for SRO Residents in Manhattan: Interim Report. Albany, New York: New York State Department of Mental Hygiene.

Pilliam, I., Sosin, M., and Westerfelt, H. (1988). Conditions Contributing to Long Term Homelessness: An Exploratory Study. The University of Wisconsin School of Social Work and the Institute for Research on Poverty.

President's Commission on Mental Health. (1978). Report to the President from the President's Commission on Mental Health. Washington, D.C.: U.S. Government Printing Office.

Price, R.H., and Smith, S.S. (1983). Two decades of reform in the mental health system (1963-1983). In: E. Seidman (Ed.), Handbook of Social Intervention. Beverly Hills: Sage.

Rog, D., Andranovich, G., and Rosenblum, S. (1987). Intensive Case Management for Persons Who Are Homeless and Mentally Ill. Rockville, Maryland: National Institute of Mental Health.

Rossi, P. (1989). Down and Out in America: The Origins of Homelessness. Chicago, IL: University of Chicago Press.

Roth, D., Bean, J., Lust, N., and Saveanu, T. (1985). Homelessness in Ohio: A Study of People in Need. Columbus, Ohio: Department of Mental Health.

Rouse V. Cameron, 373 F.2d 451 (D.C. Cir. 1966) (as amended Apr. 4, 1967).

Salem, D., Seidman, E., and Rappaport, J. (1988). Community treatment of the mentally ill: The promise of mutual-help organizations. Social Work 3: 403-408.

Sosin, M.R., Colson, P., and Grossman, S. (1988). Homelessness in Chicago: Poverty and Pathology, Social Institutions and Social Change. Chicago: University of Chicago School of Social Service Administration.

Stein, T.I., and Test, M.A. (1985). The Training in Community Living Model: A Decade of Experience. San Francisco: Jossey-Bass.

Stroul, B.A. (1988). Community Support Systems for Persons with Long-Term Mental Illness: Questions and Answers. Rockville, Maryland: National Institute of Mental Health.

Tessler, R.C., and Dennis, D.L. (1989). A Synthesis of NIMH-Funded Research Concerning Persons Who Are Homeless and Mentally Ill. Rockville, Maryland: National Institute of Mental Health.

Tessler, R., Goldman, H., and Associates. (1982). The Chronically Mentally Ill: Assessing the Community Support Programs. Cambridge, Massachusetts: Ballinger.

Toff, G., and Scallet, L. (1986). The Medicaid Waiver and Its Use in Financing Mental Health and Related Services in the Community. Rockville, Maryland: National Institute of Mental Health.

Turner, J.C., and Shifren, I. (1979). Community support systems: How comprehensive? In: L.I. Stein (Ed.), Community Support Systems for the Long-Term Patient. San Francisco: Jossey-Bass.

Turner, J.C., and TenHoor, W. (1978). The NIMH Community Support Program: Pilot approach to a needed social reform. Schizophrenia Bulletin 4:348.

Urban Institute (1984). The Reagan Record: An Assessment of America's Changing Domestic Priorities. Cambridge, Massachusetts: Ballinger.

U.S. Department of Health and Human Services (1980). Toward a National Plan for the Chronically Mentally Ill. Washington, D.C.: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services, Office of the Inspector General (1982). Board and Care Homes: A Study of Federal and State Actions to Safeguard the Health and Safety of Board and Care Home Residents. Washington, D.C.: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development (1983). Report on Federal Efforts to Respond to the Shelter and Basic Living Needs of Chronically Mentally Ill Individuals. Washington, D.C.: U.S. Department of Health and Human Services and U.S. Department of Housing and Human Development.

U.S. Department of Housing and Urban Development (1984). A Report to the Secretary on the Homeless and Emergency Shelters. Washington, D.C.: U.S. Government Printing Office.

U.S. General Accounting Office. (1988). Homeless Mentally Ill: Problems and Options in Estimating Numbers and Trends. Washington, D.C.: U.S. Government Printing Office.

U.S. General Accounting Office. (1985). Homelessness: A Complex Problem and the Federal Response. Washington, D.C.: U.S. Government Printing Office.

U.S. General Accounting Office (1977). Returning the Mentally Disabled to the Community: Government Needs to Do More. Washington, D.C.: U.S. Government Printing Office.

U.S. House Committee on Ways and Means. (1987). Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means. 100th Congress, First Session. Washington, D.C.: U.S. Government Printing Office.

U.S. House Committee on Ways and Means. (1983). Social Security Disability Insurance, Hearing Before the Subcommittee on Social Security, June 30, 1983, Washington, D.C.: U.S. Government Printing Office.

Wright, J.D. and Weber, E. (1987). New York:ess and Health. McGraw-Hill

Watt v. Stickney, 325 F.Supp. 781 (M.D. Ala. 1971), 344 F.Supp. 373 (M.D. Ala. 1972), aff'd sub nom. Watt v. Alderholt, 503 F.2d 1305 (5th Cir. 1974).

Youngberg v. Romeo, 457 U.S. 305 (1982).

APPENDIX A: DEFINITIONS

Severe mental illness: NIMH defines "severe mental illness" according to three criteria: diagnosis, level of disability, and duration of disability (Goldman, Gattozzi, and Taube, 1981; National Institute of Mental Health, 1987a). Diagnoses associated with severe mental illness include schizophrenia, depression, manic-depression, and personality disorders. Although cognitive impairments, such as dementia, are typically included within the definition of severe mental illness, there is disagreement regarding this classification. The disability dimension refers to major functional limitations such as unemployment, lack of social supports, difficulty managing money and/or obtaining financial assistance, poor hygiene, and inappropriate behavior. The duration dimension refers to a psychiatric disability that has lasted or can be expected to last 1 year or longer.

Deinstitutionalization: "Deinstitutionalization" refers to an overall reduction in the use of State mental hospitals and a general increase in the use of community mental health services that has occurred over the past 30 years. The course of deinstitutionalization has varied from State to State, but is generally characterized by four general trends. First, many severely mentally ill persons previously in State mental hospitals were discharged into the community. Second, many severely mentally ill persons who would formerly have received inpatient mental health treatment in State mental hospitals have been and are being diverted to community-based outpatient treatment programs, nursing homes, or acute psychiatric wards of general hospitals. Third, the average length of stay in traditional mental health treatment programs has been reduced. Finally, this overall shift in the locus of care has been accompanied by an expansion in the availability of community mental health services.

Homelessness: Definitions of "homelessness" vary considerably, encompassing a range of variables including lack of shelter, income, social support, or affiliation with others. Section 103 of the McKinney Act defines a homeless person as one who "lacks a fixed, regular, and adequate nighttime residence" or whose primary nighttime residence is a shelter, a "temporary institution for individuals intended to be institutionalized, or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings." The General Accounting Office (1985) defines the homeless more broadly as "those persons who lack resources and community ties necessary to provide for their own shelter." There is disagreement concerning the status of individuals living doubled up with family or friends, or persons living in welfare hotels or other inadequate housing. However, all agree that persons living on the streets or in emergency shelters are homeless.

Episode: An "episode" is a single instance of mental health care for one individual, measured from point of admission to point of discharge. A 4-day hospitalization constitutes one episode, as does a 3-month hospitalization. A series of regular visits to a community mental health center constitutes one episode of mental health care as well. From a hospital's perspective, the number of episodes of inpatient mental health

treatment in a year is the sum of all admissions during the year and the number of residents at the end of the previous year. The annual number of episodes of care in a hospital almost always exceeds the number of patients served during the year, because some patients enter the hospital more than once.